ALABAMA MEDICAID AGENCY
LONG TERM CARE REQUEST FOR ACTION FORM

Provider's Name: _____

NPI Number: _____ Provider's Area Code & Fax Number: _____

Contact Person: _____ Provider's Area Code & Phone Number: _____

Email of Contact Person: _____

Waiver Type: _____ County Number: _____ Center Number: _____

Recipient's Name: _____ Recipient's Medicaid Number: _____

Recipient's Last Four Digits of SSN: _____

REASON FOR CORRECTING LONG TERM CARE FILE:

1. Incorrect Medicaid Admission Date Requested:
   Change Date From: _____ Change Date To: _____

2. Incorrect Discharge or Death Date Requested:
   Change Date From: _____ Change Date To: _____

3. Retro Financial Eligibility Awarded:
   Change Date From: _____ Change Date To: _____

REASON FOR REQUESTED CHANGE AND/OR REJECTION REASON:

_____

_____

_____

_____

FAX REQUEST TO: KEPRO (833) 536-2134 OR (833) 536-2136

FOR MEDICAID/CONTRACTOR USE ONLY:

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_____

Date Correction Made: _____ Corrected By: _____

Confidentiality Warning: This document is intended for the use of the Individual or Entity to which it is addressed. It may contain Information that Is privileged, confidential and exempt from disclosure pursuant to the Social Security Act, Health Insurance Portability and Accountability Act, Internal Revenue Act, and other applicable laws. Disclosure of such information is subject to fines and other penalties. If you have received this communication in error, notify the Medicaid Agency immediately by telephone or fax. You should return the document with a notation that It was received in error.